Protocol for the Examination of Biopsy Specimens From Patients With Ductal Carcinoma In Situ (DCIS) of the Breast

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| --- | --- |
| **Version:** Breast DCIS Biopsy 1.0.0.0 | **Protocol Posting Date:** February 2019 |

The use of this protocol is recommended for clinical care purposes but is not required for accreditation purposes.

**This protocol may be used for the following procedures AND tumor types:**

|  |  |
| --- | --- |
| **Procedure** | **Description** |
| Biopsy | Includes specimens designated needle biopsy, fine needle aspiration and others (for excisional biopsy, see below) |
| **Tumor Type** | **Description** |
| Ductal carcinoma in situ without invasive carcinoma or microinvasion  |  |
| Paget disease of the nipple not associated with invasive breast carcinoma |  |
| Encapsulated papillary carcinoma without invasive carcinoma |  |
| Solid papillary carcinoma without invasive carcinoma |  |

**The following should NOT be reported using this protocol:**

|  |
| --- |
| **Procedure**  |
| Resection (consider Breast DCIS Resection protocol) |
| Excisional biopsy (consider Breast DCIS Resection protocol) |
| **Tumor Type** |
| Any tumor with invasive carcinoma (consider the Breast Invasive Carcinoma Biopsy protocol) |
| Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols) |
| Sarcoma (consider the Soft Tissue protocol) |

**Authors**

Patrick L. Fitzgibbons, MD\*; James L. Connolly\*, MD; Mary Edgerton, MD, PhD; Ross Simpson, MD.

With guidance from the CAP Cancer and CAP Pathology Electronic Reporting Committees.

*\* Denotes primary author. All other contributing authors are listed alphabetically.*

**Accreditation Requirements**

The use of this biopsy case summary is recommended for clinical care purposes, but is not required for accreditation purposes. The core and conditional data elements are routinely reported for biopsy specimens. Non-core data elements are included to allow for reporting information that may be of clinical value.

**Summary of Changes**

1.0.0.0 – New Breast DCIS Biopsy protocol

Surgical Pathology Cancer Case Summary

Protocol posting date: February 2019

DCIS OF THE BREAST: Biopsy

**Notes:**

**This case summary is recommended for reporting biopsy specimens but is NOT REQUIRED for accreditation purposes. Core data elements are bolded to help identify routinely reported elements.**

**Select a single response unless otherwise indicated.**

## Procedure

\_\_\_ Needle biopsy

\_\_\_ Fine needle aspiration

\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Not specified

## Specimen Laterality

\_\_\_ Right

\_\_\_ Left

\_\_\_ Not specified

## Tumor Site (select all that apply)

\_\_\_ Upper outer quadrant

\_\_\_ Lower outer quadrant

\_\_\_ Upper inner quadrant

\_\_\_ Lower inner quadrant

\_\_\_ Central

\_\_\_ Nipple

\_\_\_ Clock position (specify): \_\_\_\_\_o’clock

\_\_\_ Distance from nipple (centimeters): \_\_\_\_\_\_cm

\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Not specified

## Histologic Type (Note A)

\_\_\_ Ductal carcinoma in situ (DCIS)

\_\_\_ Paget disease

\_\_\_ Encapsulated papillary carcinoma without invasive carcinoma

\_\_\_ Solid papillary carcinoma without invasive carcinoma

## Nuclear Grade (Note B)

\_\_\_ Grade I (low)

\_\_\_ Grade II (intermediate)

\_\_\_ Grade III (high)

**Necrosis (Note C)**

\_\_\_ Not identified

\_\_\_ Present, focal (small foci or single cell necrosis)

\_\_\_ Present, central (expansive “comedo” necrosis)

## Additional Pathologic Findings (Note D)

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Microcalcifications (select all that apply) (Note E)

\_\_\_ Not identified

\_\_\_ Present in DCIS

\_\_\_ Present in non-neoplastic tissue

\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ancillary Studies

*Note: For hormone receptor and HER2 reporting, the CAP Breast Biomarker Template should be used.* [*www.cap.org/cancerprotocols*](http://www.cap.org/cancerprotocols).

Biomarker Studies

\_\_\_ Pending

## Comment(s)

## A. Histologic Type

This protocol applies only to cases of DCIS. The protocol for invasive carcinoma of the breast applies if invasion or microinvasion (less than or equal to 1 mm) is present. Pleomorphic lobular carcinoma in situ (LCIS) has overlapping features with DCIS and may be treated similarly, but at present there is insufficient evidence to establish definitive recommendations for treatment. Thus, pleomorphic LCIS is not currently included in the pTis classification.

When DCIS involves nipple skin only, without underlying invasive carcinoma or DCIS, the classification is DCIS (ie, pTis [Paget]). The majority of these cases are strongly positive for HER2.

## B. Nuclear Grade

The nuclear grade of DCIS is determined using 6 morphologic features (Table 1).1,2

**Table 1. Nuclear Grade of Ductal Carcinoma In Situ**

|  |  |  |  |
| --- | --- | --- | --- |
| **Feature** | **Grade I (Low)** | **Grade II (Intermediate)** | **Grade III (High)** |
| Pleomorphism | Monotonous (monomorphic) | Intermediate | Markedly pleomorphic |
| Size | 1.5 to 2 x the size of a normal RBC or a normal duct epithelial cell nucleus | Intermediate | >2.5 x the size of a normal RBC or a normal duct epithelial cell nucleus |
| Chromatin | Usually diffuse, finely dispersed chromatin | Intermediate | Usually vesicular with irregular chromatin distribution |
| Nucleoli | Only occasional |  | Prominent, often multiple |
| Mitoses | Only occasional | Intermediate | May be frequent |
| Orientation | Polarized toward luminal spaces | Intermediate | Usually not polarized toward the luminal space |

Definition: RBC, red blood cell.

References

1. Schwartz GF, Lagios MD, Carter D, et al. Consensus conference on the classification of ductal carcinoma in situ. *Cancer.* 1997;80:1798-1802.
2. Radiation Therapy Oncology Group (RTOG). *Evaluation of Breast Specimens Removed by Needle Localization Technique.* Available at: <https://www.rtog.org/LinkClick.aspx?fileticket=G4Pamvh2mBg%3D&tabid=290>. Accessed September 18, 2018.

## C. Necrosis

The presence of necrosis1 is correlated with the finding of mammographic calcifications (ie, most areas of necrosis will calcify). DCIS that presents as mammographic calcifications often recurs as calcifications. Necrosis can be classified as follows:

* **Central (“comedo”):** The central portion of an involved ductal space is replaced by an area of expansive necrosis that is easily detected at low magnification. Ghost cells and karyorrhectic debris are generally present. Although central necrosis is generally associated with high-grade nuclei (ie, comedo DCIS), it can also occur with DCIS of low or intermediate nuclear grade. This type of necrosis often correlates with a linear and/or branching pattern of calcifications on mammography.
* **Focal (punctate):** Small foci, indistinct at low magnification, or single cell necrosis.

Necrosis should be distinguished from secretory material, which can also be associated with calcifications, cytoplasmic blebs, and histiocytes, but does not include nuclear debris.

References

1. Schwartz GF, Lagios MD, Carter D, et al. Consensus conference on the classification of ductal carcinoma in situ. *Cancer.* 1997;80:1798-1802.

## D. Additional Pathologic Findings

If the biopsy was performed for a benign lesion and the DCIS is an incidental finding, this should be documented. An example would be the finding of DCIS in an excision for a palpable fibroadenoma. In some cases, other pathologic findings are important for the clinical management of patients.

## E. Microcalcifications

DCIS found in biopsies performed for microcalcifications will almost always be at the site of the calcifications or in close proximity.1,2,3 The presence of the targeted calcifications in the specimen should be confirmed by specimen radiography. The pathologist must be satisfied that the specimen has been sampled in such a way that the lesion responsible for the calcifications has been examined microscopically. The relationship of the radiologic calcifications to the DCIS should be indicated.

References

1. Owings DV, Hann L, Schnitt SJ, How thoroughly should needle localization breast biopsies be sampled for microscopic examination? A prospective mammographic/pathologic correlative study. *Am J Surg Pathol.* 1990;14:578-583.
2. Association of Directors of Anatomic and Surgical Pathology. *Recommendations for the Reporting of Breast Carcinoma.* Updated September 2004, Version 1.1. www.adasp.org/Checklists/Checklists.htm. Accessed June 18, 2008.
3. Silverstein MJ, Lagios MD, Recht A, et al. Image-detected breast cancer: state of the art diagnosis and treatment. *J Am Coll Surg.* 2005;201:586-597.